Salina Parks & Recreation
Special Populations Program
300 W. Ash Street, Room 100
Salina, KS 67401
(785) 309-5765

Participant Information and Medical History Form (2010)

DISCLAIMER: FORM MUST BE COMPLETE FOR PARTICIPANT TO ENROLL IN ANY ACTIVITIES.

Name:_____ Age:_____
Address:_____ Birthdate:_____
City:_____State:_____Zip:_____
Home Phone:_(___)_____
Parent/Guardian Name:_____

24 Hour Emergency Contact:

Name:_____ Relationship:_____
Address:_____ Home Phone:_(___)_____
City:_____ Work Phone:_(___)_____
State:_____ Zip:_____ Cell Phone:_(___)_____

Agency/Workshop:_____ Phone:_(___)_____
Case Manager/Supervisor:_____

Doctor:_____ Phone:_(___)_____
Address:_____City:_____State:_____Zip:_____
Medicare Card Number:_____Medicaid Card Number:_____
Allergies:_____

Medication	Dosage Time	Diagnosis

Participant's Disability: *(Please list any accommodations you may need to participate)*

_____
_____
_____

Have you been convicted of a felony or misdemeanor (non-traffic related) in the last 5 years?
A conviction will not necessarily bar you from participation. Factors such as date, nature, and number of offenses, age at the time of offense, and rehabilitation will be considered on a case by case basis by the Special Populations Supervisor.

If yes, please explain:
_____
_____
_____

Is participant subject to seizures? Y N
(If yes, please describe) _____

Does participant have special dietary needs? Y N
(If yes, please describe) _____

Does participant wear hearing aid/corrective eyewear? Y N
(If yes, please describe) _____

Does participant use any of the following? __wheelchair __walker __cane
__sign language/communication board __orthopedic/prosthetic device __briefs
Comments:_____

Does participant require assistance: __eating/drinking __orientation to people, place, time
__ anticipating safety needs __dressing/undressing __reminders __toileting
Comments:_____

Does participant display any fears? Y N
(If yes, please describe) _____

Does participant: __comply with verbal requests/directions?
__respond to specific behavioral techniques?
__attend activities with a personal assistant?
-Name Of P.A._____
-Phone Number: _____

For Overnight Trips: (*No titles, names only please!*)

Who is in charge of setting up participant's medication?
(Name) _____ (Phone Number) _____

If not to participant, who do we send important information (i.e. itinerary, rules)?
(Name) _____ (Phone Number) _____
(Address)_____ (City)_____ (State)____ (Zip Code)_____

Who is responsible for submitting Participant Information and Medical History Form, and medical profile from doctor's office?
(Name) _____ (Phone Number) _____

Please indicate any other information that might assist the Special Populations Program staff:
_____
_____

T-Shirt Size:_____
Pant/Short Size:_____

Please turn in a copy of your Photo ID when signing up for an overnight trip

PLEASE TURN IN WITH REGISTRATION